
GMC: Medical ethics education conference

Medical confidence

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Author's abstract

If medical confidentiality is not observed patients may well be reluctant to disclose information to their doctors or even to seek medical advice. Therefore, argues the author, it is of the utmost importance that doctors strive to protect medical confidentiality, particularly now when it is under threat not only in this country but also overseas.

The profession must cease to regard ethical issues to do with confidentiality, and indeed to do with all areas of medical practice, as abstract phenomena requiring no justification. If it does not then it will come under increasing and justified criticism from the community it serves.

The most important distinguishing feature of a profession is the existence of a set of ethical principles regulating the conduct of the professional towards the patient or client, transcending his own moral, religious or political views and applying throughout the whole range of professional practice. These principles apply whether the professional is in a State service or in private practice, whether he is employed in industry or the armed forces, or whether he is self-employed. It is for this reason that doctors may find themselves occasionally in conflict with legislators, with their employers or with organised labour, whose interests do not always correspond with the interests of patients either individually or collectively. It is no longer good enough to regard ethical principles as a set of sacred inscriptions in stone, to be followed, but never to be questioned. The fact is that many important ethical principles are attracting the interests of an increasingly well-informed public, eager to question their justification in the public interest, an appetite which is being amply satisfied by the press, radio and TV, all of which have realised that such topics rank highly as entertainment.

No longer can these questions be answered by referring to Hippocrates. They have to be answered by rational argument appropriate to the second half of the 20th century, and they must take full account of the recent developments which threaten the doctor-patient

relationship. The importance of full disclosure to the doctor by the patient of relevant information in personal history taking, and of the adequate recording of that information by the doctor, including the results of diagnostic tests and treatment is not generally appreciated outside the medical profession. The justification for medical confidentiality is that if it is not observed patients will be reluctant to disclose and doctors will be reluctant to record. The patient may even be reluctant to seek medical advice at all.

Court proceedings

Doctors who are compelled by subpoena to attend court, with or without records, enjoy no privilege from disclosure in this country. But they may address the judge, preferably before being sworn to give evidence, pleading that partial or, indeed, any disclosure of the information which is sought about the patient, is unnecessary or undesirable. The judge will then decide what must be disclosed. In many other countries the medical profession enjoys varying degrees of privilege from disclosure, a feature which gives rise to much controversy. The congressional record of a recent attempt to introduce uniform rules of evidence in the United States, observed that 'the partial doctor/patient privilege seemed to satisfy no one, either doctors or patients' (1). No agreement was possible, although nearly half of the States adopted the Federal Rules of Evidence, and forty out of fifty of them afford some degree of privilege. Meanwhile, it is interesting to contrast the position in this country, where no privilege exists, with that on the other side of the English Channel where French doctors enjoy an absolute privilege from disclosure (2), and the patient is not allowed to waive the privilege even in his own interests.

Statutory disclosure

An increasing number of statutes in this country require disclosure of confidential medical information, and the recent campaign by the British Medical Association (BMA) against certain clauses in the Police and Criminal Evidence Bill, shows that it is possible to challenge such measures successfully. It is, however, important to recognise that our reluctance to be

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compelled to disclose information in the interests of law enforcement contrasts strangely with our acquiescence in the compulsory notification of relatively unimportant infectious diseases such as scarlatina. Why, one may ask, are injuries received in motor vehicle accidents not compulsorily notifiable to public health authorities? They are responsible for more than half of all male deaths in the 15–19 year age group, and they are a major cause of permanent disability in the community. Their accurate recording is therefore far more important than that of certain infectious diseases.

The legal rights of minors to privacy and confidentiality

One of the more sinister attempts to erode confidentiality is the current campaign to amend the law so as to require doctors to notify parents in every case before a girl under the age of 16 can be given contraceptive advice and treatment. Such legislation is strongly opposed by the British Medical Association. Contrary to what is generally believed, there is no statutory age of consent to medical treatment. The Family Law Reform Act specifically preserved the common law ability of minors to consent to medical treatment, provided they are capable of sufficient rational understanding to make their consent valid. This must of course include the ability to understand the risks and consequences of the medical procedures concerned upon their being explained.* It is characteristic of methods adopted by the supporters of the campaign that they should deliberately confuse the position by claiming that the BMA wants to lower the age of consent to sexual intercourse which is, of course, another matter altogether. The fact that the BMA, both in its evidence to the Criminal Law Revision Committee and in its commentary on the report, opposed any lowering of the age of consent to sexual intercourse is conveniently ignored.

The experience of other countries suggests that the medical profession may have a hard struggle on its hands to preserve the right of competent minors to confidentiality and privacy in medical treatment in the face of parental counter-claims. A discussion paper issued last year by the Australian Law Reform Commission suggested that minors between the ages of 12 and 16 should have certain defined legal protection to privacy, specifically in relation to medical advice and school counselling. So bitter was the criticism of this proposal that the commission had to modify its proposals. Hundreds of letters were received and petitions were signed in churches and tabled in Parliament. The Institute of Law Research and Reform of the Province of Alberta in Canada, faced with the fact that 23 per cent of the illegitimate babies

in the province were born to minors, and that the withholding of contraceptive advice was no deterrent to their sexual activities, decided that the usual obligation of confidentiality should apply in cases where the minor adamantly refused to allow the parents to be informed. In the United States the Supreme Court has ruled as unconstitutional State legislation seeking to limit the availability of contraceptives to minors, with the result that congress has been asked to introduce federal legislation requiring doctors and others to notify parents before federally supported services of this kind are provided. The Bill, which has not yet been passed, is colloquially known as the 'Chastity Bill' or the 'Squeal Bill'.

Protection of confidentiality

There is very little evidence that either the legislature or the courts in this country are anxious to protect confidentiality. The Criminal Law Revision Committee (3) observed that 'the arguments for and against conferring a privilege in relation to communications with a medical practitioner are broadly – though not entirely – similar to those for and against conferring a privilege in relation to communications with a minister of religion. Therefore it is unnecessary to go fully over the ground in relation to medical practitioners'. In the circumstances it is hardly surprising that the committee, which completely failed to understand the reasons for medical confidentiality, should have rejected by a large majority the BMA's request for some degree of privilege. The report is careful to emphasise that the committee had kept in close touch with the Law Reform Committee, which had reached the same conclusion (4).

Although the Data Protection Bill does not require anyone to disclose medical information, attempts by the Inter-Professional Working Group, under the chairmanship of Sir Douglas Black, to persuade the Government to introduce adequate safeguards to meet the threat of intentional or inadvertent disclosure through data processing, met with blank refusal from ministers at first, and it was only as a result of persistent campaigning that success was achieved in the form of a statutory code of practice.

Even more worrying is the recent decision of the House of Lords concerning disclosure by social services departments in local government, which work closely with the medical profession and which keep records of medical information of a particularly sensitive nature. Some foster parents, upon hearing that a lay council member, who was not a member of the social services committee, wanted to see full details of their adoption application, sought an order from the High Court to prohibit full disclosure to the councillor. The High Court refused to grant the order on the grounds that any councillor is entitled to see the full report on the 'need to know' principle. The Court of Appeal overruled the High Court's decision, but its

*This interpretation of the law corresponds with the decision of the English High Court in the Victoria Gillick case. That decision has since been reversed by the Court of Appeal. The Government has given notice of appeal against that reversal.

ruling was later over-turned by the House of Lords (5). The judgements of the learned lords show little understanding of the principles underlying medical confidentiality. The consequences of the decision have been a reluctance on the part of the medical profession to co-operate with social services departments. The cost will be borne not by the doctors, not by the social services departments, but by the children concerned.

Another example is the case of *Hunter v Mann* (6), where the High Court decided that a doctor, when requested by the police under the Road Traffic Acts, must disclose information about patients who have been treated for injuries received in road traffic accidents.

Voluntary disclosure

The most difficult problem of all is the classic dilemma which a doctor may find himself in when disclosure is clearly in the interest of public safety, but the patient resolutely refuses to agree to disclosure, and there is neither a statutory nor any other kind of legal obligation upon the doctor to do so. The typical case is that of the pilot, train or car driver who develops some medical condition which is likely to cause sudden and unpredictable symptoms. The ethical position of the doctor in these cases is described in the GMC pamphlet (7) and the BMA's *Handbook of Medical Ethics* (8). Disclosure against the wishes of the patient is justifiable only in exceptional cases. However, it is worth remembering that a doctor's first duty is to safeguard the health of his patient, and the patient in such cases is just as likely to kill or injure himself as anyone else.

The other classical dilemma is that of the doctor who treats a dangerous criminal. There is no legal obligation upon a doctor in this country to disclose the fact to the police, and we are therefore unlikely to witness the spectacle of doctors being prosecuted for aiding and abetting criminals in this country. In other countries the position may be very different, as in the United States where Dr May was sentenced to two years' imprisonment for failing to notify the police that he had treated John Dillinger, then public enemy number one, for gun-shot wounds – notification in such cases being required under a local statute. A *Lancet* editorial proclaimed that 'colleagues in every country will applaud Dr May's action in not betraying a professional trust' (9) – sentiments which were deeply resented by the American press, which was well aware of the consequences of allowing a desperate and homicidal criminal to roam at large.

There remains a grey area in which the justification for voluntary disclosure is highly controversial. One such case came before the Disciplinary Committee of the General Medical Council in 1978 (10). A family planning clinic had notified a family doctor, in strict confidence, that it had prescribed an oral contraceptive for one of his patients, then aged 16. Without seeking her permission the doctor promptly informed her parents. The doctor concerned disagreed with the

treatment given by the clinic and decided that a discussion of the matter with the parents was essential to the girl's welfare. No attempt was made to obtain her consent. The president of the GMC was careful to emphasise that the decision to dismiss the charge must be limited to the circumstances of the particular case. It is doubtful whether such a lenient view would have been taken if the recent guidelines had been in force.

There are, of course, less sensational ways in which doctors may agree to disclose medical information voluntarily, and without the consent of the patient. The commonest is for purposes of *bona fide* research, of which the national cancer register is probably the most longstanding and best known recipient. In all such cases the doctor must satisfy himself that the applicant is a fully trained research worker, committed to preserving confidentiality, and that the information required is really needed for the purpose of the research. It is particularly important to ascertain the nature of the ultimate disposal of the information provided. The BMA frequently advises doctors on such applications, and it has become increasingly common for research workers to seek the *imprimatur* of the BMA before approaching doctors for medical information.

Information about a patient who has died

Finally, there is one issue which has never been resolved satisfactorily, that is the extent to which, if at all, the fact that the patient is no longer alive, modifies the principle of confidentiality. Most people would question the legal position in libel whereby technical and inadvertent damage to reputation can attract colossal damages during life, whereas there is no remedy at all if the injured party dies, however gross the libel. Conversely, one can question the fact that the principle of medical confidentiality appears to apply equally whether or not the patient is still alive. The question attracted much public interest about eighteen years ago when a complaint was brought by a doctor against Lord Moran who had published in a book certain medical details about the health of Winston Churchill to whom he had acted as medical attendant for many years. The fact that this ethical complaint had ever been brought against Lord Moran would never have been known, because all ethical cases are dealt with by the BMA in the greatest secrecy, had it not been for the perspicacity of a reporter at the Writ Office who noticed that one Charles Wilson (as Lord Moran used to be known) was seeking an injunction against the BMA to prohibit certain proceedings. The results of those proceedings will of course remain confidential, even though Lord Moran himself died some years ago.

It can be argued that it is of legitimate importance to the public to know when illness in those occupying prominent positions in public life may have caused decisions or events which have resulted in public disaster. On the other hand, disclosure can cause much anguish to surviving relatives. The question which

should be asked is 'would a patient have been either reluctant to seek medical advice, or to disclose information essential to diagnosis or treatment, for fear that information might be disclosed after death?' If the answer is 'No' there can be no case for regarding disclosure as unethical. If the answer is 'Yes', the decision must depend upon the circumstances and the way in which the information is given.

Information about the cause of death is already available for public inspection on the death certificate. Is it to be seriously argued that medical information challenging the cause of death should be suppressed on grounds of confidentiality? The danger here, as with most ethical issues concerning medical practice, is that such issues are still regarded as abstract phenomena, requiring no justification. So long as the medical profession takes this point of view our blind adherence to these 'abstract phenomena' will come under increasing and justified criticism from the community we serve.

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